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SEE ARTICLE ON PAGE 22

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Alliance Spine and Pain Centers is one of the premier interventional spine and pain practices in the U.S., and has been recognized locally and nationally for the achievements of our practice and our individual physicians. Our practice offers board certified, fellowship trained anesthesiologists practicing cutting edge interventional pain management between 15 locations including 11 state of the art ASC's in GA. The practice further boasts of former academic leaders who held positions of Director of Pain Management and Pain Fellowship at Emory, Associate Professor of Anesthesiology at Emory and faculty at Medical College of GA. in Augusta. Many of our physicians have been published and/or won awards. Alliance's highly skilled Anesthesiologist focus on non-surgical, image-guided procedures that help return patients to work and improve quality of life. In many cases, these patients can return to normal activities or avoid more invasive treatments. Spine treatment procedures are clinically proven and follow the guidelines of American Society of Interventional Pain Physicians. Our state-of-the art outpatient centers are Joint Commission accredited.

CONDITIONS TREATED

- Hip Pain – Degenerative Disc Disease
- Neck Pain – Spondylosis
- Back Pain – Disc Herniations
- Occipital Headaches
- Nerve Root Impingements
- Vertebral Compression FX
- Spinal Cord Injury nerve pain
- Radiculopathy/Sciatic – Cancer
- Reflex Sympathetic Dytrophy RSD/CRPS
- Diabetic Neuropathy
- Facet Pain – SI Joint Dysfunction
- Trigger Point Injections

NON-SURGICAL TREATMENTS

- Epidural Steriod Injections/Discograms
- Selective Nerve Root Blocks/Facet Blocks
- Diagnostic Nerve/Lumbar sympathetic blocks
- Radiofrequency Ablation
- Major Joint Injections/Stellate Ganglion Block
- SI Joint Injections/Medial Branch Blocks
- Peripheral Nerve Blocks
- Celiac Plexus Blocks/Spinal Cord Stimulator
- Occipital Nerve Blocks
- Hypogastric Plexus Blocks
- Vertebroplasty/Kyphoplasty

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Treating Patients Appropriately With Opiate Pain Medications

Pickens A. Patterson, III, M.D. Board Certified in Anesthesiology and Pain Medicine
Alliance Spine and Pain Centers

A well-trained pain specialist is uniquely qualified to recognize and manage all of the many intricacies associated with prescribing narcotic pain medications, where appropriate, following a work injury. It has been shown that treating pain adequately in the early stages of injury increases the likelihood of recovery and return to function, whether requiring opioid or non-opioid pain medications.

Clearly **all patients suffering an injury do not require opiate medications.** However, those that do should be required to undergo screening to identify a high risk for opiate abuse and misuse. **Screening may be as simple as a questionnaire inquiring about the patient's family history as well as their personal history with opiates and illicit drugs.** Patients identified as high risk should be treated with opiates only if deemed absolutely necessary and monitored more closely than a low risk patient.

Patients treated with opiates on a chronic basis (generally greater than 90 days) should be required to read and sign an opiate agreement with the prescribing physician. This agreement describes the risks associated with narcotic medications, the reason they are being prescribed and what the physician requires of the patient as well as what the patient should expect from the physician. **If a patient and physician are unable to reach an agreement as to how the patient will be treated in writing, narcotic medications should not be prescribed.**

The urine drug screen is expensive, but provides invaluable information to the treating physician. It shows if the patient is taking the prescribed medication, taking a non-prescribed medication or taking illicit drugs or another medication that may interfere with their narcotic pain medication. **The state of Georgia requires a physician to test a patient's bodily fluid randomly at least every three months while being treated with narcotics.** Other forms of testing include blood and saliva. Physicians may employ random pill counts where a patient is called in and advised to bring in their bottle and the pills are actually counted. Most patients are required to be seen monthly.

The pain physician also has a responsibility to appropriately respond to any aberrant behavior which may include failed urine drug screens, frequently lost medications or prescriptions, frequent requests for early refills and appearing intoxicated. Depending the behavior, a physician may counsel a patient, advise the patient that they will no longer prescribe opiate medications, (continue to treat with non-opiates and interventional procedures) or discharge a patient from his care and even notify the authorities if warranted.

If a patient is discharged the physician should provide a clear treatment plan for the patient which may include substance abuse treatment. The physician should provide a list of other treating physicians in the area of the same specialty and a letter describing the reason for discharge.

Pickens A. Patterson, III, M.D.

Pickens A. Patterson, III, M.D. is Double Board Certified in Anesthesiology and Pain Management Medicine. He has eight years of experience in practicing Interventional Pain Management in South Carolina and Georgia.

Dr. Patterson attended the United States Naval Academy. He later completed his internship and residency in anesthesiology at Vanderbilt University where he was awarded "Best Bedside Manner" by the director of his fellowship program. He Patterson grew up in the College Park/Southwest Atlanta area, not far from the Camp Creek Medical Center where his office is located. His wife, Cristale, is also a native of College Park and they have two young sons. Dr. Patterson intends to provide the most up to date treatments for chronic pain to the Atlanta metropolitan community for many years to come.

WH WORKPLACE HEALTH

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INJURY PREVENTION TIPS
SHOULDER & ELBOW

Robert M. Titelman, M.D.
Resurgens Physician

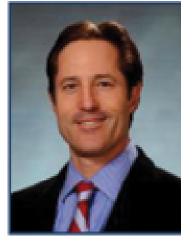
The best way to maintain a healthy body is prevention. Avoiding fractures of the shoulder and elbow involve common sense workplace safety, by avoiding falls. This is facilitated by keeping floors dry and clean, and ladders and railings secure. Workplace safety training is helpful as well.

To avoid acute traumatic muscle, ligament and tendon tears, fall avoidance is paramount, utilizing the same approach as for fractures. However, many tears come from repetitive or cumulative trauma. Many cumulative trauma injuries occur from lifting. When lifting, it is important to keep the carried object close to the body. The object is from the body, the more force is transmitted to the elbow, shoulder and torso. This is similar to a crowbar, in its leverage effect. This is especially important when doing overhead lifting, which puts extra stress on the shoulders.

Prior to engaging in lifting and repetitive activities, it is important to maintain flexibility. Stretching the arm across the body, and up overhead against a wall, are very helpful exercises for the shoulder, loosening up the back of the shoulder and rotator cuff. Stretching the wrist up and down with the elbow straight keeps the elbow tendons limber, helping to avoid tendonitis and tennis elbow.

Strengthening the rotator cuff with 5-10 pound weights, rotating out and in with the elbow by the side, will keep the rotator cuff healthy. Wrist curls with the palm up, as well as down, with 1-5 pound weights will keep the elbows healthy.
An ounce of prevention is better than a pound of cure, but when pain begins to occur, it is best to stop the activity as soon as safely possible and seek medical attention.

REPETITIVE STRESS & CARPAL TUNNEL INJURIES



Glenn J. Jonas, M.D.
Worklink Physician Liaison
Resurgens Regional Board Member

Repetitive Stress Injuries (RSI's) Whether you sit at a desk in front of a computer or do outdoor heavy manual labor you are susceptible to repetitive stress injuries (RSIs) or cumulative trauma disorders (CTDs). The repetition of the work activity you may do every day can cause a cumulative injury to the soft tissues of the body. Over time, this micro trauma can result in pain and the inability to perform work activities. The good news is that most of these injuries can be avoided by improving the environment and technique required to perform one's individual job functions. Ergonomics is this study of the relationship between the work and the worker. Nearly 2 million workers per year will suffer ergonometric injuries. Worker's compensation claims have nearly tripled in the past two decades. A majority of this increase can be attributed to inadequate ergonometric conditions in the workplace.

Carpal Tunnel, tendinitis and tenosynovitis are the most common disorder we treat as Hand Surgeons. The incidence is only growing as greater numbers of our work force are set behind a computer screen for much of the working day. The repetitive nature of keyboard operations can be minimized by several actions. Detachable keyboards that can be adjusted for comfort and variation of hand and wrist position. Different mouse designs that will allow dispersion of the stress to the upper extremity. Adjustable height chairs, cushioned arm and hand rests to decrease stress on joints and tendons. In addition, frequent short work breaks for specialized stretches have been found to be beneficial in preventing symptoms and improving comfort. When all else fails, a visit to a Hand surgeon for a trial of steroid injection can be helpful prior to considering Carpal Tunnel release surgery.

If conservative treatment fails , carpal tunnel releases will in most cases solve the issue. Whether done open or endoscopically, the results are uniformly good. Expectation is for a full release to work in approximately 3-4 weeks for an endoscopic release and 6 weeks for an open release. The surgery simply enlarges the passageway at the wrist where the nerves and tendons pass. With less pressure on the median nerve, the symptoms resolve quickly.

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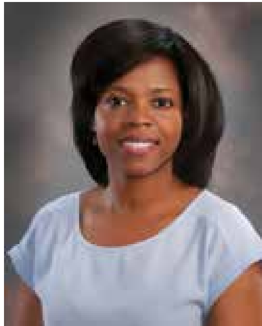
Does Pain Management Ever End?

Chinonye Orizu, M.D.

Patients often ask, “Does pain management ever end?” It is a common misconception that pain management is a black hole that patients enter, only to never return. In addition, pain management is threatened by the risk of prescription drug abuse and the financial burden treatment places on society. To accurately answer this question requires a basic understanding of the treatment of pain.

In past decades, it has become well accepted that the most effective management of pain involves a multidisciplinary approach. A true multidisciplinary approach entails the use of multiple modalities (e.g. medications, physical therapy, massage therapy, nonsurgical interventional procedures, behavior modification, etc.) provided by a team of specialists. At Spine Care & Pain Management we educate patients on their diagnosis and provide treatment options specific to their needs. This approach decreases the possibility of opioid tolerance and/or risk of prescription drug abuse, while at the same time offering the best chance of successful treatment. It is vital that patients understand that it is not always possible to obtain complete pain relief, however decreased pain is always desired. Educating patients on this concept will decrease their perception that incomplete pain relief is equivalent to therapy failure; a fallacy.

In many cases, patients may have conditions requiring long-term chronic pain management. In these situations, it is imperative that patients are involved in their plan of care to effectively attain the best outcomes.



It is our goal as interventional pain specialists to decrease our patients’ pain, along with their reliance on medications, so that they can engage in their life’s activities, as opposed to withdrawing. In our practice many patients have reached this goal and have been successfully discharged from pain management.

Chinonye Orizu, M.D.
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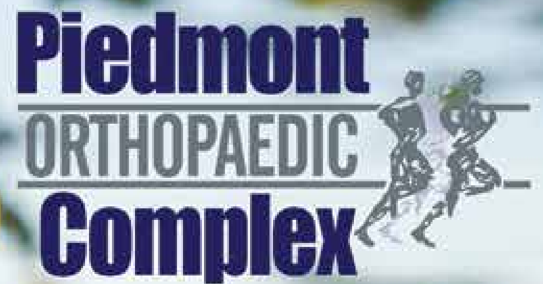

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The workers' compensation department at Piedmont Orthopaedic Complex is committed to helping patients restore function and get back to work as quickly as possible.

With a combined team of orthopaedic, spine, and foot & ankle specialists, Piedmont offers both conservative and minimally invasive options that reduce pain, shorten recovery periods, and empower patients to get their life back.

Piedmont is committed to building strong relationships in the workers' compensation field that are based on open communication. We look forward to learning more about your business and your needs.

Learn more about our workers' compensation program at www.PiedmontOrthoComplex.com/workerscomp

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Rainy Weather and Joint Pain: Is There a Link?

Dr. DeCoons,* M.D.*, Orthopaedic Surgery & Sports Medicine

Does the rate of complaints of joint pain at your workplace seem to skyrocket on rainy days? Many patients report noticing changes in the severity of their pain associated with changes in the weather. We all have that one coworker who swears to the ability to predict an afternoon rain shower based on a sensation in their knee. Is there really a link between joint pain and the weather? Dr. Ryan DeCoons, an orthopaedic surgeon at Piedmont Orthopaedic Complex, offers insight.

There is no consensus scientific link between joint pain and weather changes. Nevertheless, based on strong anecdotal evidence from patients, many experts believe there may be a link between the two.

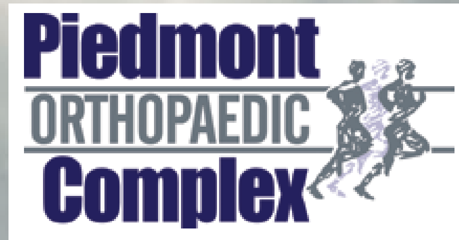
Many of our patients attribute any worsening in their pain to cold, damp, or rainy weather. Most scientists, however, believe that the most likely association between weather changes and joint pain is actually related to barometric pressure. Barometric pressure is the weight of the atmosphere that surrounds us. Barometric pressure often drops before rainy weather sets in. This lower air pressure pushes less against the body, allowing tissues to expand, and these expanded tissues can put pressure on our joints. This affects everything within the joint, including the joint lining, called the synovium, as well as the ligaments within the joint.

All of these tissues have nerve endings in them, and patients may experience changes in the weather as tightness or stiffness within the joint. Furthermore, patients with chronic pain may have nerves that are more sensitized due to injury, inflammation, scarring, or adhesions, and they may be more sensitive to these pressure changes. A similar phenomenon has been noted in patients with migraine headaches, who also note changes in their symptoms related to weather patterns. Barometric pressure changes, as well as changes in humidity and temperature, might affect the pressure in the brain, or the way the brain blocks pain.

Regardless of the science behind it, if you are experiencing worsening joint pain with weather changes, it is real to you. So what can you do to minimize your joint symptoms as the weather changes?

1. Stay warm: Dressing in layers, keeping your home heated, and warming up the car before getting in can help ease pain related to cold weather, according to the National Institutes of Health. Apply a heating pad to your painful joints.
2. Try to prevent swelling: Warmth may help with joint pain, but not necessarily swelling. If rainy weather worsens arthritis in your hands or knees, try wearing spandex gloves or a neoprene knee sleeve to keep fluid out of the joints.
3. Keep moving: Before going outside when it has been raining, try exercising your painful joints to loosen them up. Stretching indoors and jogging in place (especially if you are going for a run), as well as heat creams and heating pads, can help loosen up stiff joints. Make sure you warm up well to stretch out tight muscles prior to athletic activity in cold weather, and wear protective clothing to keep the muscles and joints warm during outdoor exercise.

Dr. DeCoons, M.D.
Orthopaedic Surgery & Sports Medicine



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Pain Institute of Georgia is a leader in diagnosing and treating work-related injuries.

Our physicians:

CARLOS J. GIRON, M.D.

- Interventional Pain Management Physician and founder, Pain Institute of Georgia
- IME Training: ABIME, SEAK, 5th & 6th Ed. AMA Guidelines
- IME Certifications: CIME, Georgia MPWCP
- Founder & Executive Director of Georgia Society of Interventional Pain Physicians
- Co-author ASIPP Interventional Pain Management Clinical Practice Guidelines 2.0
- Member of Georgia State Board Workers' Compensation Medical Committee

PRESTON C. DELAPERRIERE, M.D.

- Interventional Pain Management Physician, Pain Institute of Georgia
- Medical Director, Sweet Dreams Anesthesia 2013 to Present
- State of Georgia Medical MPWCP
- ACLS/BLS Certified
- Bibb County Medical Society
- American Society of Anesthesiologists
- Georgia Society of Anesthesiologists
- American Society of Interventional Pain Physicians
- Georgia Society of Interventional Pain Physicians

JULIAN M. EARLS, JR., M.D.

- Chief Neurologist, Pain Institute of Georgia
- President, Middle Georgia Medical Society
- American Academy of Pain Management
- Georgia Society of Interventional Pain Physicians
- American Society of Interventional Pain Physicians
- Georgia State Medical Association
- National Forum of Independent Pain Clinicians
- National Headache Foundation

Pain Institute of Georgia is a multi-disciplinary comprehensive Pain Management medical practice. It is our goal to make the treatment process as smooth as possible. **We are devoted to providing the safest and most appropriate care for the injured worker.** We understand the Georgia Workers' Compensation system, and our treatment plans focus on achieving maximum medical improvement (MMI) as quickly as possible.

The goals of our Workers' Compensation program:

- **Return employee to previous levels of activity and functionality**
- **Focus on Improvement of physical and emotional wellness**
- **Return employees to work quickly and effectively**
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Interventional Pain Physicians 11th Annual Pain Summit Summary

Carlos J. Giron, M.D., Founder and Executive Director: cgiron@bellsouth.net

The largest organization of Interventional Pain physicians in Georgia met recently at the Georgia Society of Interventional Pain Physicians 11th Annual Pain Summit March 20 – 22, 2015 at Lake Oconee, Georgia.
Some of the many current topics addressed in depth by at the 2015 Pain Summit:

The Reciprocal Relationship between Sleep and Pain:
• Exploring the bi-directional relationship between pain conditions and sleep
• Interconnections of total and partial sleep deprivation and pain thresholds and the potential neurobiologic mechanisms governing these relationships.

Latest Update on Georgia Legislation Regarding Medical Marijuana and Medical Marijuana in the Treatment of Chronic Pain:
• Consensus was that more scientific evidence and studies are needed for physicians to even consider cannabinoids in clinical care of any condition.
• Healthy discussion took place regarding new legislation in our State for medical cannabis use for treatment of a small select group of conditions and disorders. Representative Allen Peake spoke to the attendees and engaged in the discussions.

Incorporating Genetic Testing to Optimize the Management of Pain:
• Recognizing the barriers associated with inadequate pain assessment and treatment, along with ways to overcome these barriers and provide appropriate pain management.
• Incorporating genetic testing into the management plan for treating pain in order to identify individuals with potential addiction issues.

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• shorter rehabilitation
• less invasive than the traditional Total Knee Replacement approach.

Established in 1961, Macon Orthopaedic and Hand Center (now OrthoGeorgia) has grown with the Middle Georgia region, earning a far-reaching reputation for unrivaled excellence.

What hasn't changed in almost half a century, however, is the center's unflagging dedication to the twin values upon which it was founded: compassion and skill. "Like the city we proudly call home, our practice has gained statewide, national, even international recognition, "says Waldo Floyd III, M.D., "yet we continue to reflect our founding mission of genuinely caring about the people who share our community". "Our doctors, nurses, therapists, technicians, and staff are committed to offering world-class orthopaedic care to our hometown family right here in Macon, Georgia."

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A Rehabilitative Approach to Pain Management

Paul L. Mefferd, D.O.

Why does Pain Management carry such a negative stigma and often feel like a black-hole abyss for so many workers' compensation cases? The answer may lie in the approach, used by many pain management physicians, of treating patients based primarily on subjective complaints. The typical treatment regimen often entails prescribing high-dose narcotics, numerous other medications, removal from work and general deconditioning and inactivity, all of which lead to functional loss for the patient. This approach is called palliative pain management and is inappropriately applied to injured workers too frequently.

While many physicians offer only a palliative treatment approach, The Physicians' are unique in that we take a rehabilitative approach to pain management. Rather than focusing only on the claimant's subjective complaints of pain and self-perceived disability, We instead focus on functional gain and returning the claimant back to work whenever possible. After the acute injury phase, we try to limit opioid medications in most instances. The medical literature supports our belief that prolonged pain medication use actually impedes injured workers' recovery and likelihood of returning to work, and even leads to prolonged disability.

A rehabilitative pain management approach requires physicians to look beyond the 'pain behaviors' with which the claimant may present. Treatment is physician-controlled utilizing actual functional gains as the benchmark for the appropriateness of the treatment. Simply treating a claimant's pain complaints is usually not beneficial alone. Often physical and behavioral rehabilitation are encouraged in combination with medical and injection therapy.

When it comes to work injuries, a rehabilitative approach is best for all involved and, most significantly, more favorable for the claimant looking to return to a productive, functional and meaningful life.

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Work Health Solutions

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Medical Marijuana Questions and Preparation

James Smith, Esquire with Hall Booth Smith, P.C.

Georgia law is clear that in the event that an injury is deemed compensable, the employer must provide the injured worker with medical treatment which is prescribed by a licensed physician, and which "shall be reasonably required and appear likely to effect a cure, give relief, or restore the employee to suitable employment." Less clear, however, is how the law will be applied if-or perhaps more aptly, when-Georgia passes legislation to legalize marijuana for medicinal purposes.

The Georgia House of Representatives has already sent a bill allowing the use of cannabis oil for certain restricted medicinal purposes to the Senate for approval this year, and with 23 other states that have already legalized the "Schedule I" drug in some capacity, it would seem that legalization in Georgia is an inevitability.

In the context of workers' compensation, the legalization of marijuana will certainly create an array of legal questions, not the least of which include the cost of the drug, its viability, and how legalization may impact the "intoxication defense" or "drug-free workplace" programs in the state. In that regard, Georgia will be looking to other states which have already begun dealing with such issues.

The Court of Appeals in New Mexico, for example, determined in January of 2015 that medical marijuana was "reasonable and necessary" for an injured worker who had failed traditional pain management methods. Undoubtedly, the time for Georgia to answer these questions is fast approaching, and it's high time that employers begin to prepare.

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McKenzie Method of Mechanical Diagnosis & Therapy (MDT) – Not all Physical Therapy Created Equally

Raphael R. Roybal, M.D. Orthopaedic Surgery and Spine Surgery
Chatham Orthopedic Associates, P.A.

Evidence Based medicine including accurate diagnosis and effective treatment is crucial for the successful treatment of spinal pathologies. Specifically, the incidence of back pain and the billions of dollars spent each year in the United States treating back pain demands that the proposed treatments undergo vigorous scientific scrutiny evaluating their efficacy. The McKenzie approach of Mechanical Diagnosis and Therapy (MDT) has been rigorously evaluated in peer reviewed journals. MDT continues to be the most researched physical therapy based method available. As such, the evidence supports MDT as one of the few effective conservative treatment options for patients with mechanical back pain and associated symptoms. MDT consists of various aspects which the treating physician must understand when prescribing an effective treatment plan for the patient suffering from back injuries.

Assessment:

Integral to the success of MDT, A reliable and diagnostically valid assessment must be made for each individual patient. Reliability means that two different examiners will agree on the assessment findings and come to the same conclusion when assessing each patient. In most cases, the evaluators would be the treating physician and the physical therapist trained in MDT. Because treatment decisions rely exclusively on the patient, assessment is critical. Kilpikoski, et al. and Razmjou, et al. have demonstrated that the Mckenzie approach applied by credentialed therapists results in a reliable assessment and diagnosis. Conversely, it has also been shown that therapists lacking full training in MDT do not accurately assess and are therefore unable to deliver consistent treatment to their patients with this method.

The second part of the diagnostic process is the accuracy of the assessment when compared to a diagnostic standard. Donelson, et al. and Laslett, et al. demonstrated the accuracy of key findings in the McKenzie assessment and their relation to diagnostic injections. These are the first studies that find that any physical examination process can accurately predict the findings of diagnostic and therapeutic spinal injections.

The McKenzie MDT approach also has a unique feature absent in other approaches: The ability to predict patient treatment outcome. Centralization of a patient's pain or a lack of centralization is a key predictor of patient outcome. More specifically, if a patient with lumbar or cervical pain can have their symptoms centralized in a short time after initiating MDT, the prognosis for a rapid and lasting improvement is likely.

Treatment:

In 2004, Long et al. replicated clinical experience with a land mark study. This study clearly endorses the value of sub-classifying patients using a McKenzie assessment, establishing the patient's directional preference, and giving the patient specific exercises based upon these findings thereby positively affecting outcomes in regard to pain, function, and medication use. These results dramatically demonstrate that non-specific exercises do not have the same clinical efficacy. The MDT assessment and the specific interventions based on individual patient presentations determines patient outcomes. Another example of superior results with the McKenzie method is illustrated by Alexander, et al. in the management of herniated lumbar discs. Patients who had a confirmed lumbar herniated disc with loss of leg strength and/or sensation achieved a successful non-operative resolution with MDT if they could centralize their symptoms and achieve full passive extension. The results showed 91% of the patients who achieved this were able to avoid surgery at 5 years follow-up.

Prevention:

In a military population, the regular performance of passive extension exercises resulted in a decrease in the report of low back pain as well as a reduction in disability related to low back pain over a one year timeframe.

Conclusion:

In summary, the McKenzie method has probably undergone more scientific scrutiny than any other physical therapy method. Although frequently preformed, passive modalities have poor support in the peer reviewed literature. In contrast, the evidence supports MDT as a reliable, valid, and effective conservative treatment option for patients afflicted with back pain.

Rotator Cuff Tears

James W. Duckett III, M.D. Academy Orthopedics LLC

The rotator cuff is a group of four muscles that is vitally important in normal shoulder function. The muscles that make up the rotator cuff include the supraspinatus, infraspinatus, subscapularis and teres minor. Collectively, these smaller muscles act to stabilize the shoulder joint while the larger muscles provide the power to raise your arm overhead. The rotator cuff is often mistakenly referred to as the "rotary cup," "rotator cup," and "rotor cuff."

Rotator cuff tears are a common shoulder injury that results in pain and functional limitations. Tears can result from a single traumatic injury or can occur with wear and tear over time. Arthroscopic rotator cuff repair has proven to be an effective procedure for treating symptomatic rotator cuff tears. Arthroscopic surgical techniques result in improved pain and quicker recovery and mobilization.

Accurate diagnosis is made through a combination of thorough patient history, physical examination and diagnostic imaging such as x-ray and MRI. Many rotator cuff injuries can be treated conservatively with physical therapy and possible subacromial injection.
When conservative treatment methods fail to improve function and symptoms, surgical options may be considered.

Tips for Using an Interpreter

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1. Be sure to get the right language. Did you know that some languages include various dialects? Determining the right language need is the first important step.

2. At the appointment, speak directly with your client. Stay in first person. Rather than saying, "Ask him who was driving", it is better to ask, "Who was driving?"

3. Allow time for the interpretation. Please be aware that there may not be an equivalent word in the target language and it may warrant a description of the term. The target language may also be significantly briefer than English as well.

4. Professional interpreters do more than just repeat what you are saying. They preserve confidentiality, accuracy and ensure culturally competent service. Using a friend or family member as an interpreter can severely compromise privacy. If you arrive at an appointment and realize you need an interpreter, it is handy to have an agency's phone number on hand. This way, you may communicate with an interpreter on the line.
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A Word From The Chairman

The Honorable Frank R. McKay, Chairman State Board of Workers' Compensation

As we begin 2015, we have a lot going on at the Board.

The Board will be conducting its annual regional educational seminars across Georgia in March and April. Our seminars will be in Macon, Albany, Savannah, Kennesaw, and Augusta. The Public Education Committee of the Advisory Council, led by Chair, Sy Jenkins, has worked diligently to develop an entertaining and educational program. Our program will address issues for business, medical, insurance, and legal fields. I encourage you and your clients to attend.

In addition to our regional seminars, we are currently making final preparations for the Board's Annual Seminar at the Atlanta Hyatt Regency on August 31st, 2015 through September 2nd, 2015. Our Steering Committees have been working throughout the year on our program. We will be sending out shortly, and posting on our website, the program and registration information. I encourage you and your clients to attend.

The Legislative, Rules, Medical, Licensure and Rehab Committees of the Advisory Council have been working hard and are in the process of making a number of recommendations to the Board in 2015. One of the successful results of the Advisory Council in the past has been the creation and implementation of the Form WC-205, utilized by medical providers to efficiently obtain authorization for treatment. For this year, of particular importance, the Rehab Committee has worked on a number of recommendations to improve Board Rule 200.1 dealing with catastrophic cases. Over the next months, our Rules Committee is going to work with the Rehab Committee to finalize any updates by July 1, 2015. This is a culmination of a lot of work by a lot of people which is greatly appreciated by the Board.

This is going to be a challenging year for the Board as we look to upgrade ICMS, our web-based paperless system. As a practicing lawyer for over 20 years, I valued the Board's foresight in going paperless with ICMS in 2005. When ICMS was implemented, it revolutionized the practice of workers' compensation. I personally enjoyed being able to view a file, along with filing documents instantly. To this end, when I first became Chairman, I noticed our technology infrastructure, along with ICMS, was aging. As such, my top priority has been to ensure we implement ICMS – II, an upgrade to our current ICMS system.

Our primary goal in 2015 is to implement ICMS II. Based on the initial proto-types, ICMS II will provide the same functions as ICMS I—online filings, ability to view files, etc., but will be accessible to more users. When implemented, I believe you will appreciate the benefits of ICMS II.

Finally, one of my top goals is for the Board to provide efficient service to our stakeholders. Here are some highlights for 2014:

For our Trial Division, we received approximately 14,880 hearing requests. These requests were up 1% from 2013. From the date of the hearing request to resolution of the issues, the Trial Division is averaging 113 days. So, in less than four months, most cases are resolving. When a case does go to a hearing, our judges are issuing decisions in less than 60 days in over 94% of the cases.

After a decision is issued by a trial judge, appeals may be filed with the Appellate Division. In 2014, the Appellate Division issued approximately 600 awards, with over 90% being issued in 90 days or less.

Our ADR section had a great year in 2014. The ADR section conducted over 2,200 mediations, with close to 90% resolving the pending issues. Our ADR judges issued approximately 550 orders. The ADR section has consistently provided parties in our workers' compensation system with quicker resolution and arguably more satisfying results, which in turn has reduced time and costs for our workers' compensation system.

As an aside, due to the success of ADR in resolving so many issues in cases, sitting as the Presiding Judge on the Appellate Division, I have noticed the cases left to be tried and appealed are generally ones with challenging factual and/or legal issues.

Finally, I am extremely proud of our Settlements Division. We approved close to 15,000 settlements in 2014. This was an increase by 4% over 2013. Of the settlements submitted, over 94% were approved in 10 days or less.

This is going to be a challenging year for the Board, and with your help and support, I am confident we will be able to achieve our goals. I wish everyone a successful and prosperous year in 2015.

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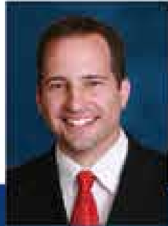
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A Patient's Guide to Platelet Rich Plasma Therapy

Platelet Rich Plasma (PRP) Therapy

While most current treatments for chronic tendon injuries don't provide long term relief, Platelet Rich Plasma Therapy (PRP) is a treatment option for non-healing tendon injuries. PRP Technology was initially developed 20 years ago for heart surgery to aide with wound healing and blood loss.

PRP's benefits are now being applied to the facilitation of healing tendon injuries that affect the elbow, shoulder, knee, and Achilles tendon. Patients should consider PRP treatment if they have been diagnosed with a tendon injury in which conservative treatment such as anti-inflammatories, physical therapy and bracing have not provided symptomatic relief.

To find out if PRP is a viable treatment option for you, an evaluation will be scheduled and MRI may be performed prior to injection to ensure that there is not a major tear in the tendon that should be treated with surgery.

The PRP injection usually takes about an hour, and is performed at the **Bone & Joint Institute of South Georgia** as an outpatient procedure. You will be instructed not to take any anti-inflammatories for one week prior to the injection, as this will limit treatment benefits.

Patients can expect to see significant improvement in symptoms, such as elimination of the need for more traditional treatments like medications, cortisone injections or surgery; and a dramatic return of function.

PRP is designed to promote the long-term healing of the tendon, and is not a quick fix. The process of PRP requires time and rehabilitation to allow the injured tendon to heal properly. Most patients saw 81% improvement in 3 months. Through regular follow-up visits your doctor can determine when you're able to resume regular physical activities.

How does PRP Therapy work?

Using the patient's own blood, specially prepared platelets are taken and then re-injected into the tendon of the affected area. These platelets release substances known as growth factors that lead to tissue healing. For example, when you cut yourself, the body's natural response is to attract platelets that release growth factors and facilitate the healing. By concentrating the platelets we increase the growth factors up to eight times, which promotes the healing of tendons. While other tendon injury treatments such as corticosteroid injections may provide temporary relief and stop inflammation, PRP injections actually heal the tendon over a period of time.

The human body has a remarkable ability to heal itself, and by re-injecting concentrated platelets we can facilitate that natural healing process.

The **Bone & Joint Institute of South Georgia** provides the full range of orthopedic services, including non-surgical and surgical treatments, and on-site Open MRIs in Jesup and Waycross. From a sprain to a severe injury requiring surgery, BJISG is your first choice for comprehensive, compassionate orthopedic care.

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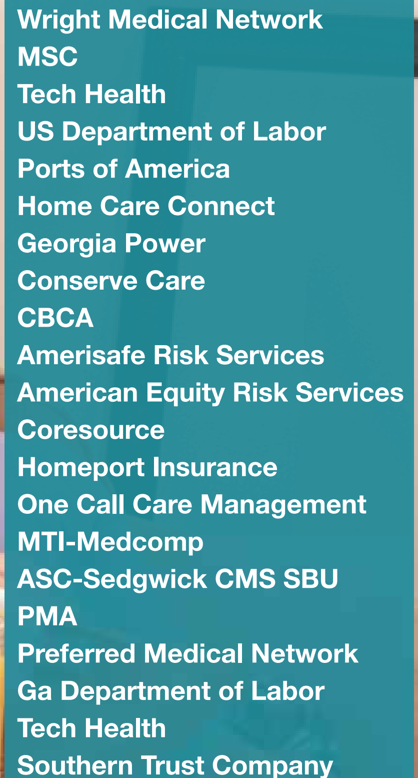

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Medical Imaging Management – Reducing Delays & Reschedules

Mindy Meece, President, Velocity Medical Management, LLC

With the rising cost of claims and an increasingly heavy workload, both financial and administrative burdens are decreased for employers, adjusters, case managers and physicians through the use of specialty networks. These networks frequently offer savings below state fee schedules, minimize additional delays throughout the claim cycle and are powerful administrative partners to any workers' compensation organization.

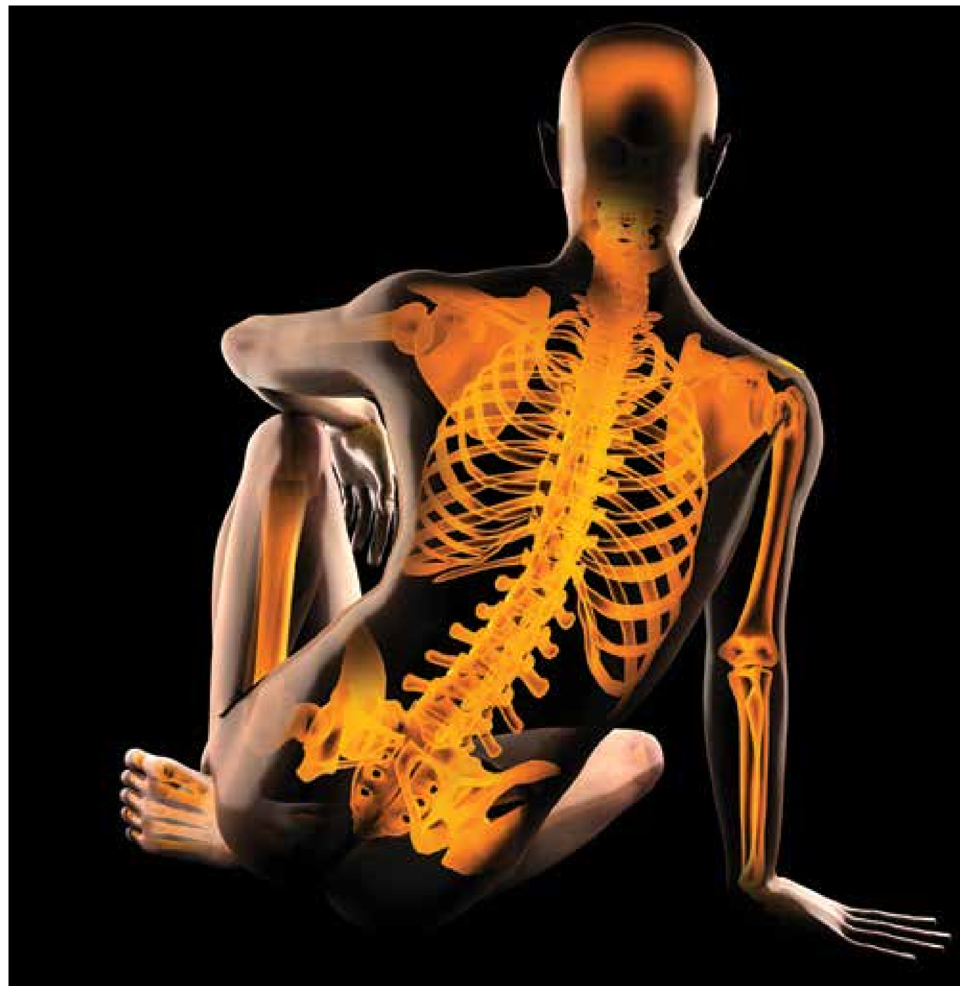
Incorporating medical imaging management into your workers' compensation program is a win-win for everyone involved.
Adjusters and case managers are able to dedicate more time to different aspects of the file, while trusting the patient will receive fast, efficient, quality care. Physician offices have a helping hand during the authorization, scheduling and reporting processes. And finally, patients experience the convenience and flexibility of a geographically and modality diverse network of imaging facilities.

Networks are dedicated to aligning the technical needs and preferences of the treating physician, with a properly equipped and accredited imaging facility, while considering patient availability and location. Addressing these items are key to a successful outcome and positive claimant experience. Care coordinators have the training and resources to help mitigate delays through process and follow-up, while ensuring all involved parties stay informed.

Some of their functions include:

- **Obtain missing prescriptions and updated contact information**
- **Coordinate and help secure lab results for contrast patients**
- **Confirm paperwork with providers prior to patient arrival**
- **Confirm patient attendance**
- **Collect and distribute medical reports**
- **Obtain comparison readings to previous diagnostic reports if patient history exists**
- **Initiate addendum requests for missing comparisons or aging**
- **Reschedule missed appointments due to no-shows, equipment maintenance/ malfunction, unexpected claustrophobia, etc.**

Medical imaging is a valuable tool used in most workers' compensation claims to properly diagnose an injury and/or clear an injured worker back to full-duty status. There is no question expediting and streamlining the process from referral to billing is an added value. However, and more importantly, managing the unexpected and avoidable delays which potentially arise during the process can be the difference between a completed imaging appointment or a rescheduled imaging appointment, a timely follow-up visit or a rescheduled follow-up visit, a happy worker or a litigious claimant, and a closed claim or an open claim.



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Hand Laceration Treatment

Joshua A, Ratner, M.D.-The Hand & Upper Extremity Center of Georgia, P.C.

Among the most common reasons for hand surgery consultation after a work-related accident is a hand laceration. The complex anatomy of the hand makes even a seemingly simple cut a potentially serious injury. While urgent evaluation by an emergency room or urgent care center is recommended, subsequent follow up with a physician experienced with the detailed examination of the injured hand is essential.

Initial management should always include infection prevention. Wounds should be irrigated to eliminate contamination. Antibiotics and tetanus prophylaxis are given when indicated. In the event of excessive bleeding, pressure is applied to the wound either by hand or with a reinforced bandage. Uncontrolled bleeding or gross contamination may be an indication prompt surgical care. When possible, a thorough examination to assess tendon function, nerve function, and vascular status should be performed. Findings should be documented. Wounds should be covered with non-stick dressings and loosely placed bandages.

If there is concern about injury to structures deep to the skin, prompt (within 2-3 days) evaluation by a hand surgeon is required. Early recognition and treatment of hand injuries is an important predictor of successful outcomes. Delayed treatment in the case of tendon and nerve injuries complicates surgical care and compromises rehabilitation.

Surgical management and rehabilitation of patients with hand injuries requires the expertise of those specially trained in the field. Hand surgeons and certified hand therapists have completed specialized training to ensure accurate diagnosis, skilled surgical and non-surgical management, and optimized patient outcomes.

Dr. Ratner graduated cum laude from Jefferson Medical College, where he was selected to the Alpha Omega Alpha Medical Honor Society. He completed an orthopedic surgery residency at the University of Pittsburgh Medical Center and Children's Hospital of Pittsburgh. Dr. Ratner continued his training at the Philadelphia Hand Center where he served a fellowship in Hand and Upper Extremity Surgery. Prior to joining the Hand and Upper Extremity Center of Georgia, he was a member of the medical staff at the Shriners Hospital for Children in Philadelphia where he specialized in treating pediatric hand trauma, congenital differences, spinal cord injury, and brachial plexus palsy. Dr. Ratner is Certified by the American Board of Orthopaedic Surgery. Dr Ratner holds a Subspecialty Certificate in Surgery of the Hand from the American Board of Orthopaedic Surgery.

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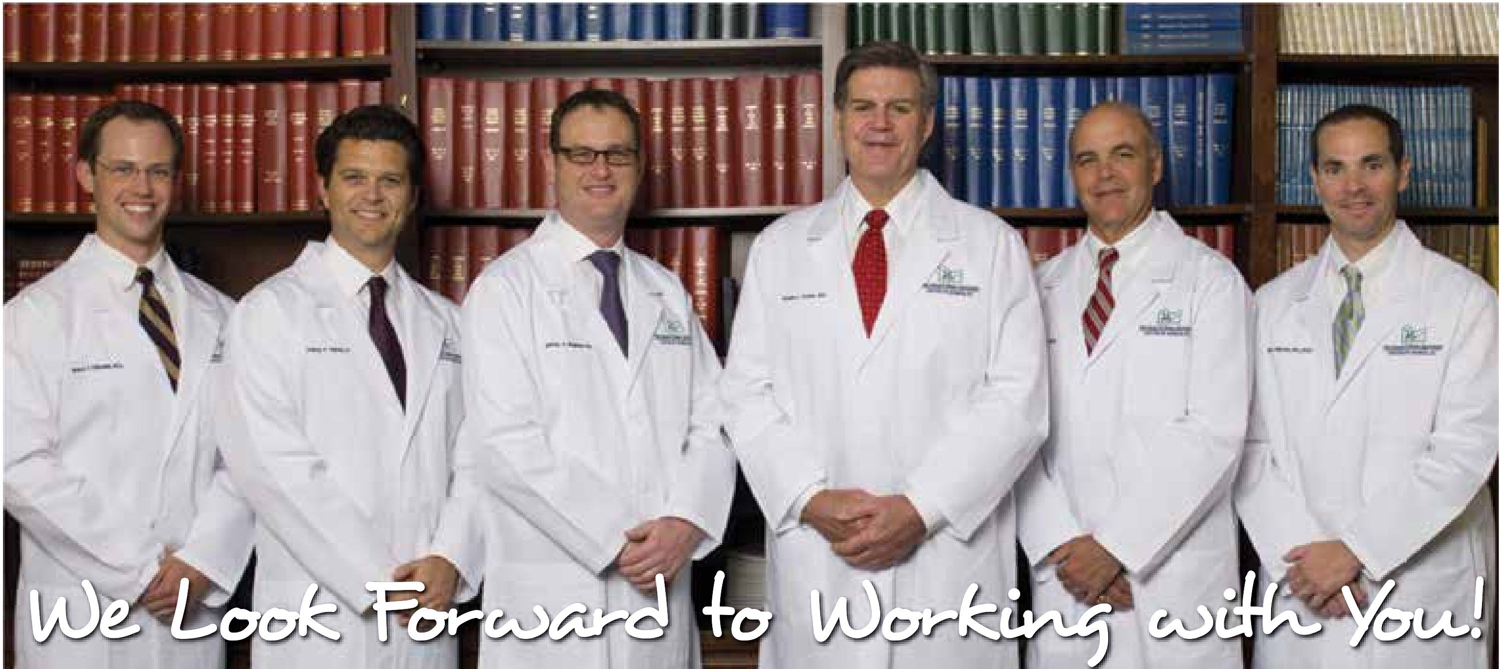

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- Working closely with the State Board of Workers' Compensation on regulatory issues.
- Daily presence at the State Capital during Legislative sessions.
- Monitoring case law and advising members of workers' compensation issues, legislative changes and court cases.
- Spring and Fall Conferences provide members with networking opportunities, educational seminars, as well as opportunities for open discussions with state and business leaders.

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GWCA thanks the members, exhibitors and sponsors for attending the 2015 Spring Conference at Callaway Gardens.

GWCA has always been an advocate and voice for employers but previously represented only self-insured and high-deductible companies. It is our belief that all employers should have a supporter and a way to be heard, so we have expanded our membership to all employers that do business in Georgia. It is our goal to be part of an ongoing dialogue between the members and those at the state level to facilitate change and improve our workers' compensation system.

For more information about joining GWCA, please contact:
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ATHENS ORTHOPEDIC CLINIC

Rotator Cuff Disease: Shouldering the Pain

By: Brad Register, MD

Brad Register, MD

Do you ever have pain in your shoulder when playing overhead sports such as tennis and swimming, or during painting and construction work? Does this pain worsen with activity? Is it located in the front or side of your shoulder? If so, you may have damage to your rotator cuff. The rotator cuff is the term used to describe four muscles in the shoulder that play an important role in shoulder function. These muscles help hold the ball (humeral head) in the socket (glenoid), playing a vital role in lifting and rotating the shoulder. Comprised of many muscles, ligaments and joints, the shoulder has a wide range of motion. The rotator cuff helps to provide stability and strength throughout this motion, making it susceptible to injury and pain.

Pain in the rotator cuff can come from tendinitis, subacromial bursitis (inflammation of the tissue surrounding the rotator cuff), or rotator cuff tears. Tendinitis and bursitis often result from a condition known as subacromial impingement syndrome. When the arm reaches overhead, the rotator cuff is caught between humeral head and the bone on top of the shoulder (acromion). People who frequently hold their arms in this position are susceptible to rotator cuff damage. Initially this causes inflammation, but over time can lead to partial or full-thickness tear. This explains why rotator cuff pain may develop after an injury to the shoulder, or present with seemingly no inciting event.

Rotator cuff tears can result from a combination of extrinsic and intrinsic causes. Chronic impingement on the undersurface of the acromion bone can eventually lead to a partial or a full-thickness tear. Tears can also result from a fall where the patient lands directly on the shoulder or arm. Likewise, the tendons of the rotator cuff can fail over time from intrinsic degeneration caused by repetitive use and tensile overload.

Patients with rotator cuff pain often develop tenderness in the front or side of the shoulder and discomfort when lifting the arm or lowering the arm from an overhead position. Initially pain can be related to arm movement and relieved by rest, but eventually pain at night develops. Weakness and stiffness commonly progress, making it difficult for patients to reach behind the back also.

The initial treatment of rotator cuff disease is conservative by utilizing rest, anti-inflammatory medications and physical therapy. The goals of therapy are to improve motion and strength, often leading to pain reduction. A steroid injection into the bursa just above the rotator cuff can help reduce pain, but relief from this is often temporary, and these shots cannot be repeated too many times for fear of damaging the shoulder's soft tissues.

When nonsurgical methods fail to relieve pain, surgery may be recommended. If pain is coming from bursitis or a partial thickness tear, the physician may only have to remove the bursa and flatten out the underside of the acromion bone to relieve the impingement. Patients will typically feel much better within 2-3 months. If the patient has a full-thickness or high-grade partial-thickness rotator cuff tear, the surgeon can repair the cuff using minimally invasive arthroscopic surgical techniques. Following rotator cuff repair, physical therapy is utilized and full recovery can take 6 months or more. Occasionally the tear is irreparable but fortunately several treatment options exist for these cases as well.

As an added convenience for patients, we offer a dedicated Internal Case Manager who works closely with our Workers' Compensation clients to ensure optimal care and attention. Having our own case manager allows for frequent and effective communication among employers, nurse case managers, adjustors and attorneys, resulting in prompt care and more positive outcomes.

If you would like to discuss the care of your employees, or if you have questions about any of the services we offer, please call Dr. Joseph Sativz, Medical Director of the Occupational Health Center, or **Jennifer Herring, Director of Workers' Compensation/Internal Case Manager, at (706) 433-3259.**

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